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## **MEDICARE PHYSICIAN GROUP PRACTICE DEMONSTRATION**

### **New Demonstration Program Tests Financial Incentives for Improved Quality and Coordination in Large Group Practices**

Many physician practices and other supportive practices that are not directly reimbursed by Medicare can lead to better patient outcomes and lower overall health care costs. For example, there is good evidence that by anticipating patient needs, especially in those patients with chronic diseases, health care teams that partner with patients and coordinate across physicians can help implement physicians' plans of care effectively, reducing the need for expensive procedures and hospitalizations for preventable complications. Electronic record systems, emails, telemedicine, and other innovative approaches can help patients not only avoid costly complications, but perhaps even avoid the need for some office visits.

Outside of Medicare, there is growing evidence that effectively-designed payments for improving patient results can lead to better patient outcomes and lower total costs, by giving physicians the flexibility to adopt approaches like these that may work better for individual patients. This differs from Medicare's current payment system, which reimburses physicians based on the number and complexity of specified services and procedures that they provide.

Medicare is now starting to implement performance-based payments for physicians to provide better financial support for better care. The Physician Group Practice (PGP) Demonstration is the first pay-for-performance initiative for physicians under the Medicare program. The PGP Demonstration rewards physicians for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries. Mandated by Section 412 of the Benefits Improvement and Protection Act of 2000, the PGP Demonstration seeks to:

- Encourage coordination of Part A and Part B services,
- Promote efficiency through investment in administrative structure and process, and
- Reward physicians for improving health outcomes.

During the three-year project, CMS will reward physician groups that improve patient outcomes by coordinating care for chronically ill and high cost beneficiaries in an efficient manner.

The Physician Group Practice Demonstration seeks to align incentives for physician groups to manage the overall care of their patients, especially beneficiaries with chronic illness who account for a significant proportion of Medicare expenditures. Because they will share in any financial savings that result from improving the quality of care, the groups will have incentives to use electronic records and other care management strategies that, based on clinical evidence and patient data, improve patient outcomes and lower total medical costs.

The Demonstration enables CMS the ability to test physician groups' responses to financial incentives for improving care coordination, delivery processes and patient outcomes, and the effect on access, cost, and quality of care to Medicare beneficiaries.

### **Demonstration Overview**

Physician groups participating in the demonstration will continue to be paid on a fee-for-service basis. Physician groups will implement care management strategies designed to anticipate patient needs, prevent chronic disease complications and avoidable hospitalizations, and improve quality of care. To the extent they implement these strategies effectively to improve care, physician groups will be eligible for additional performance payments.

Performance payments will be derived from savings expected through improvements in care coordination for an assigned beneficiary population. Beneficiaries are assigned to the physician group if they receive the plurality of their outpatient visits at the group. Performance targets will be set annually for each group based on the growth rate of Medicare spending in the local market. Performance payments may be earned if actual Medicare spending for the population assigned to the physician group is below the annual target. Performance payments will be allocated between efficiency and quality, with an increasing emphasis placed on quality during the demonstration. The demonstration is required by law to be budget neutral.

Physician groups will use a variety of care management strategies to improve care under the demonstration. These include increased use of disease management and case management services; improving access to primary care physicians, geriatricians, and nursing staff; and improving patient monitoring and quality of care through the use of electronic medical records, disease registries, and evidence-based guidelines.

### **Measuring Quality**

Effective pay-for-performance systems require effective measures of performance as their foundation. The ambulatory care measures -- those that look at the quality of care available in doctors' offices -- are part of Medicare's comprehensive efforts to improve the quality of care delivered to Medicare beneficiaries. The measures were developed by CMS working in an extensive process with the American Medical Association's Physician Consortium for Performance Improvement and the National Committee for Quality Assurance to measure improvements in care. The measures from this process were submitted late last year for review and comment to the National Quality Forum, a non-profit organization that represents a broad range of health care stakeholders and provides endorsement of consensus-based national standards for measurement and public reporting of healthcare performance data.

CMS also worked with the physician groups to develop a consensus agreement around how the measures would be captured and used to assess performance and reward quality under the demonstration. As a result of this process, the demonstration will use a total of 32 measures that focus on common chronic illnesses and preventive services, listed in the following table.

PGP Demonstration Quality Measures			
Diabetes Mellitus	Congestive Heart Failure	Coronary Artery Disease	Preventive Care
HbA1c Management	Left Ventricular Function Assessment	Antiplatelet Therapy	Blood Pressure Screening
HbA1c Control	Left Ventricular Ejection Fraction Testing	Drug Therapy for Lowering LDL Cholesterol	Blood Pressure Control
Blood Pressure Management	Weight Measurement	Beta-Blocker Therapy – Prior MI	Blood Pressure Control Plan of Care
Lipid Measurement	Blood Pressure Screening	Blood Pressure	Breast Cancer Screening
LDL Cholesterol Level	Patient Education	Lipid Profile	Colorectal Cancer Screening
Urine Protein Testing	Beta-Blocker Therapy	LDL Cholesterol Level	
Eye Exam	Ace Inhibitor Therapy	Ace Inhibitor Therapy	
Foot Exam	Warfarin Therapy for Patients HF		
Influenza Vaccination	Influenza Vaccination		
Pneumonia Vaccination	Pneumonia Vaccination		

### **Physician Group Practices**

Health care groups with at least 200 physicians were eligible to apply to participate in the demonstration. Multi-specialty physician groups with well-developed clinical and management information systems were encouraged to apply.

CMS selected ten physician groups on a competitive basis to participate in the demonstration. The groups were selected based on a variety of factors including technical review panel findings, organizational structure, operational feasibility, geographic location, and demonstration implementation strategy.

The demonstration will test the new incentives in diverse clinical and organizational environments including freestanding multi-specialty physician group practices, faculty group practices, physician groups that are part of integrated health care systems or that have affiliations with hospitals and/or other providers, and physician network organizations.

The ten physician groups represent 5,000 physicians and over 200,000 Medicare fee-for-service beneficiaries. The physician groups participating in the demonstration are:

- Dartmouth-Hitchcock Clinic, Bedford, New Hampshire
- Deaconess Billings Clinic, Billings, Montana
- The Everett Clinic, Everett, Washington
- Geisinger Health System, Danville, Pennsylvania
- Middlesex Health System, Middletown, Connecticut
- Marshfield Clinic, Marshfield, Wisconsin
- Forsyth Medical Group, Winston-Salem, North Carolina
- Park Nicollet Health Services, St. Louis Park, Minnesota
- St. John's Health System, Springfield, Missouri
- University of Michigan Faculty Group Practice, Ann Arbor, Michigan

### **Quality Improvement Strategies**

Under the demonstration, physician groups will enhance existing programs activities and develop new strategies for improving care for the Medicare fee-for-service population, especially

chronically ill and high cost beneficiaries. These strategies include disease management and case management programs as well as increased use of information technology to facilitate care coordination. Highlights of each physician group's implementation plans are described below.

**Dartmouth-Hitchcock Clinic** The physician practice of Dartmouth-Hitchcock Clinic that serves New Hampshire and Vermont will apply care management practices and programs developed under commercial managed care to Medicare fee-for-service beneficiaries. Disease management initiatives will focus on beneficiary outreach and education about routine and preventive care services and follow up for targeted chronic diseases programs. Using this planned care model the Dartmouth-Hitchcock clinical team will partner with our Medicare patients with a special focus on those patients living with congestive heart failure, diabetes, coronary artery disease, hypertension, pulmonary disease and beneficiaries with high cost or complex medical conditions.

**Deaconess Billings Clinic** will focus on reducing the need for inpatient admissions and emergency management of chronically ill Medicare fee-for-service beneficiaries through care management strategies. The strategies rely on electronic medical records and computerized physician order entry systems; case management programs; development and dissemination of system-wide disease management protocols and practices focusing on beneficiaries with diabetes, CHF, CAD, and preventive services; and improved coordination of end of life care.

**Forsyth Medical Group** will use care management and disease management models and practice guidelines to coordinate the care of high risk Medicare fee-for-service beneficiaries and chronically ill beneficiaries to reduce their admissions to acute care facilities and to coordinate services they need. Disease management programs will target Medicare fee-for-service beneficiaries with diabetes, COPD, coronary artery disease, stroke, congestive heart failure, and dementia. Individualized plans of care will be developed for high-risk beneficiaries that will identify appropriate treatment, and an active reminder system will be utilized for timely follow-up care by physicians, case managers, as well as for patient follow-up.

**Geisinger Health System's** mission is to enhance quality of life through an integrated health service organization based on a balanced program of patient care, education, research and community service. Under the demonstration, all Medicare beneficiaries cared for by the Geisinger Health System will be encouraged to take advantage of Geisinger's award-winning, internet-based patient health record system (*MyGeisinger*). *MyGeisinger* gives Medicare beneficiaries convenient access from home to their medical records as well as providing secure communication with their full team of healthcare providers.

**Marshfield Clinic (MC)** will expand existing and create new care management programs that anticipate and address health care needs of the Medicare beneficiary population. MC physicians will integrate these programs with the care they provide. Within these care management programs, MC will measure attributes of clinical quality, practice performance and cost of care. Then, MC will use principles of process improvement to develop systems and processes that facilitate optimal performance with respect to those attributes. The care management programs are based on the Institute of Medicine's aims for health care in the 21st century: safe, effective, patient-centered, timely, efficient and equitable. MC will leverage its innovative and advanced information, communication and telehealth systems to facilitate optimal care and customer service. The programs focus on prevention: primary (disease prevention), secondary (early disease detection) and tertiary (slow progression and minimize complications of chronic

diseases). Specific examples include: vaccinations, cancer screening, fall prevention, hypertension, cardiovascular diseases, diabetes, chronic lung disease, depression and dementia.

**Middlesex Health System** and its affiliated physicians plan to apply the same care coordination and quality improvement infrastructure developed for managed care populations and the uninsured to Medicare fee-for-service beneficiaries. Plans include increasing the use of community based, patient-centered chronic care management programs for asthma, diabetes, and congestive heart failure; improving communication and coordination of care among physicians, the hospital, skilled nursing facilities, homecare agencies, and other community-based services; piloting physician home visits to the high-risk homebound elderly; and assisting individual physician offices in quality measurement and performance improvement within their own practices in the areas of chronic care and prevention targeted by the demonstration project.

**Park Nicollet Health Services** will design and pilot a comprehensive model supporting patients with chronic diseases, focusing initially on Diabetes, Congestive Heart Failure and CAD. The model looks at the necessary components of self-management support, delivery system changes, decision support and clinical information systems necessary for productive interactions between informed activated patients and a prepared practice team.

**St. John's Health System** plans to expand its medical management model developed for its managed care operations to also serve the Medicare fee-for-service population. By using the strengths of an integrated delivery system this model is designed to identify those with chronic care needs and provides for management and coordination of both inpatient and outpatient services. Patients with specific needs will have access to full continuum case management, 24/7 telephonic nurse triage, social worker facilitated care transition, outpatient preventive and disease management programs, and palliative care. St. John's Clinic physicians will utilize a computerized information system to track quality indicators. Specific disease management programs to be expanded to the Medicare fee-for-service population include diabetes, congestion heart failure, asthma, and chronic obstructive pulmonary disease.

**The Everett Clinic** will take a comprehensive approach to integrate demonstration incentives into the governance and management structure of the clinic and apply new and existing programs to current and new Medicare fee-for-service beneficiaries residing in their service area. In addition to various health maintenance programs, disease management programs will focus on CHF, CAD, hypertension, diabetes and anti-coagulation; and will incorporate expanded outcome measurement reporting.

**The University of Michigan Faculty Group Practice (UMFGP)** will apply population-based medical management interventions to increase quality and improve efficiency of health care for Medicare fee-for-service beneficiaries. The new care model includes care coordination for high risk and complex patients; disease management for patients with heart failure, coronary artery disease, diabetes, depression and Chronic Obstructive Pulmonary Disease (COPD); coordinated transitional care among acute, ambulatory and long-term care providers; an emergency department team to improve the care of patients in the emergency room and avoid hospital admission if appropriate; and increased access to geriatric clinics and programs for early identification and treatment of conditions. Electronic medical records and patient registries will be used to coordinate, monitor and direct care, including increasing use of evidence based guidelines. In addition, the demonstration will allow UMFGP to train the next generation of

health care providers in new models of care, and to transfer the lessons learned from the demonstration to other purchasers in Michigan.

**For More Information**

The demonstration is scheduled to begin April 1, 2005. For additional information, visit the Physician Group Practice webpage at [www.cms.hhs.gov/researchers/demos/PGP.asp](http://www.cms.hhs.gov/researchers/demos/PGP.asp)

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